Authorization to Release Medical Records:

PATIENT INFORMATION:

Name (print)_____DOB: _____

SSN:_____ MA#_____

INFORMATION TO BE SENT TO:

Provider Name:_____ Facility Name:_____

Address:_____ PH: FAX:

_____ INITIAL HERE IF TWO WAY RELEASE

INFORMATION TO BE RELEASED FROM:

Provider Name: _____ Facility Name: Marriage and Family Solutions

Address:___7818 Big Sky Drive #101 Madison WI 53719_____ PH:608-203-6267 FAX:608-203-6696

INFORMATION TO BE RELEASED: (check all that apply)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays, and special tests

_____ All Medical Records

_____Verbal communication regarding:_____

_____ Other: (please specify)

PURPOSE FOR WHICH THE DISCLOSER IS BEING MADE: (check all that apply)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

*****EXCLUDE the following information from the records released: (please initial)***

_____Drug/Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease

_____HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or psychiatric diagnosis/treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). ***I may revoke this authorization in writing.*** To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I have the right to inspect or receive a copy of the health information to be used or disclosed and this authorization.

Signature:_____ Date:_____

(Patient, guardian, or authorized representative)

THIS AUTHORIZATION WILL EXPIRE 1 YEAR FROM THE DATE SIGNED